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INSIDE

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American Health Consultants® is A Medical Economics Company

The care's been provided, now comes the tough part: Who gets the bill?

Automated COB check said to be on the horizon

Determining the proper coordination of benefits (COB) — which insurance company should pay when an individual has multiple coverage — long has been a thorn in the side of access departments. With tougher screening by insurance companies and the move toward capitation, the issue fast could become a matter of financial life and death for a health care organization.

Failure to ask patients such questions as, "Are you employed?" and "Do you have group health insurance?" when they offer the spouse's insurance card costs a health care organization time and money. Typically, insurers delay paying claims, saying they're not sure if theirs is the primary coverage. Insurers wait for responses from patients, who may have tossed out a letter asking which insurance is primary. Three months later, the hospital still hasn't been paid.

"What a patient tells you on a form is no longer interesting because the machine can tell you faster."

When the hospital begins assuming risks under a capitated system, the stakes get much higher as profit margins get slimmer. **(See related story, p. 62.)** A health care organization may find itself getting paid nothing for providing care to a member's spouse, when the patient's own insurance would have paid the entire tab.

A solution to the problem is on the way, according to COB Clearinghouse Corp., an Independence, OH-based company that claims to have the first automated method of performing COB on health insurance and drug card plans. Founded in 1993, the company has been laying the groundwork for a system that will revolutionize the way patients are registered, says **Patrick Lawlor**, president.

The key to bringing the system to fruition is convincing large health plan sponsors, both governmental and corporate, that they will benefit by signing on to a universal database, he explains. When that happens, the service will become available, Lawlor adds. "Until we've gotten most of the third-party administrators [TPAs] and carriers involved, it's not ready for release."

Providers lack knowledge about risk, study reveals

A national study of trends in managed care capitation and risk transfer between health plans and providers reveals that more than 30% of those surveyed admit to having little understanding of the level of risk for which they have contracted.

A large percentage of providers are completely unaware of the type of reinsurance coverage they carry to insure against their risk, according to a report in *The Managed Care Indicator*, published by Evergreen Re, a consultant and reinsurance broker to the managed care industry with offices in Stuart, FL, Edina, MN, and Richmond, VA.

Despite this lack of knowledge, providers attribute 36% of their revenue to capitated contracts and expect this trend to continue over the next five years. Two-thirds of those currently in capitated contracts say they will seek an average of 2.6 new contracts this year. One-third of organizations not currently accepting capitated members will sign an average of 1.9 new contracts in 1999.

Over the next five years, survey participants say, capitated revenue is predicted to reach 47%, an increase of 11% over 1998.

The survey included administrators from 161 physician groups (multispecialty and single-specialty) and 161 hospitals with 200 beds or more in managed care markets throughout the nation with 30% or greater HMO penetration. ■

With that in mind, the company offers a retrospective audit service that shows health plan sponsors how much money they're losing because a plan member's primary insurance is not identified, he says. One audit uncovered an employee who had four fully active health insurance policies in force at the same time, notes **Todd Swanson**, COB vice president.

"Rather than relying solely on enrollment forms, our system searches patient social security numbers through the top 300 third-party administrators / insurance carriers' eligibility gateways and immediately determines if other coverage exists," says **Susan Muha**, a spokeswoman for COB Clearinghouse. "Once other coverage is found, an algorithm is run consisting of six COB rules established by the National Association of Insurance Commissioners. Primacy is instantaneously determined."

The idea, Lawlor says, is to persuade the company that its TPA cannot do the coordination of benefits by hand. "We get clean identification information on everybody, not just spouses but children, and put it in a centralized database. We show, for example, a major carrier's biggest customers that they've missed a lot of COB events — that 10% of the claims they've paid, someone else should have paid."

With the average employee using $3,800 in health benefits a year, that's important information for the plan sponsor to have, he points out.

Working with the Department of Defense on its CHAMPUS coverage, COB Clearinghouse already has found that a significant number of military dependents thought to have no other coverage are, in fact, covered by other insurance plans, he says.

"We are also accurately performing COB on drug claims," Muha adds. "There are 350 million drug cards floating around in the United States and only 260 million Americans. Only about 200 million of those have insurance."

Until now, no coordination

People tend to use the drug card or the insurance card with the lowest co-payment, and until now, those cards have not been coordinated, Muha points out. In the case of at least one carrier she is aware of, insured persons are not covered if they fail to provide current COB information. "The next time they go to the emergency department, the provider won't get paid."

Meanwhile, Lawlor advises access managers to prepare themselves for the most efficient way of registering patients. The service could be on line as early as Jan. 1, 2000, he says.

A fee scale has not yet been established, but the company likely will charge a minimal sum for participation plus a per-transaction charge, Swanson notes. COB may pilot its service as early as next month in a regional area, he adds.

Using a modem or a point-of-service credit

card machine, an access employee will be able to enter pertinent information, such as a patient's social security number, policy number, or name and address, and find out on a national basis if that individual has other insurance.

Registrars won't have to copy insurance cards or get the patient to fill out forms, although they may choose to do so, Lawlor notes. "What a patient tells you on a form is no longer interesting because the machine can tell you faster. With a dedicated telephone line, the [user] can get the answer back in one second."

He likens the improvement in efficiency to the speed of an automatic teller machine vs. that of a bank employee, he says. "Not only will you verify eligibility on a plan, you will find out if that plan is primary and receive a gross schedule of benefits. You'll be told that there is a $250 deductible, or 80-20 co-pay insurance. You may still have to do precertification, but you will get the [toll-free] numbers to do that expeditiously."

The COB service also will be of interest to the billing and receivables department, Swanson points out, particularly in cases where the primary coverage may change. "The patient may be admitted for one thing and treated for something else.

"There may be coverage that's primary for an appendectomy but doesn't include vision care," he says. "If in the hospital, the patient gets a sliver in his eye, the hospital will have to determine which coverage is primary in that case. So [hospitals] will inquire not only at the point of admission, but also at the time of billing to ensure the procedure done is billed to the proper carrier."

Discounts offer incentive

COB Clearinghouse recently arranged for several leading companies providing reinsurance for health plans to offer a 10% discount to plans that sign on to the COB interface, Lawlor says. That would give those plans a significant budget reduction for health care, he adds. The COB service will use the same electronic gateway as the 270 standardized transaction set, one of the data sets under the Health Insurance Plan Portability Act of 1996 required for electronic data interchange beginning in February 2000, he notes.

Electronic billing inquiries to Blue Cross or Aetna, for example, will go from the health care provider to the TPA or insurance company, as the system now stands. The TPA or insurance company may not have correct COB information, Swanson points out.

What COB Clearinghouse will do instead, Lawlor explains, is answer that inquiry directly and determine the primacy of coverage. "It will be a simpler journey and a more complete answer." ■

Need More Information?

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Different focus creates new access paradigm

ScrippsHealth goes outside usual job mix

It's time to find a different design for access services. At least that's the view at ScrippsHealth in San Diego, where top managers are thinking outside the box, emphasizing employee education access priorities.

With that in mind, the health care organization is advertising two positions aimed at helping create the access department of the future: quality audit specialist and compliance educator. Each position will require a person with specialized skills, and each will have a pay range of between $48,000 and $61,000, says **Leonard Womack**, CPC-H, manager of coding management and compliance.

The quality audit specialist position, he says, is in part an outgrowth of ScrippsHealth's recent commitment to becoming certified in ISO 9000, a quality management system created by the International Organization for Standardization in Geneva. **(See *Hospital Access Management*, October and November 1998.)**

"We were already compliant with the traditional JCAHO [Joint Commission on the Accreditation of Healthcare Organizations] regulations," Womack says. "But from the business office standpoint, JCAHO doesn't really impact the patient's perception of quality. JCAHO requires certain things to ensure good record keeping and patient confidentiality. However, the patient is never asked what it is about their experience that they see as quality problems."

Teaching takes place anytime, anywhere

As part of its effort toward more formalized training for access employees, ScrippsHealth in San Diego recently purchased an educational software program, says **Leonard Womack**, manager of coding management and compliance.

The software, produced by M3: The Healthcare Learning Company in Dallas, comes with several programs on such topics as compliance, fire safety, and patient confidentiality, he says. "Employees can log on and do educational programs on line," Womack adds. "It will register the time spent on line, the areas in which [the employee] has obtained education, and the test scores achieved in completion of those programs."

The organization will make time available during work hours for the programs that are mandated as a requirement for employment, he says, while the programs that are offered for the employee's career advancement may be handled differently.

"Most professionals approach education on their own time," Womack points out. "Maybe the [employee] could log on from home, or maybe we'll set up time within the business environment. We will probably wait to find out what the person we hire thinks. We don't want to make it so difficult that the [employee] doesn't want to do it. On the other hand, they need to take a certain amount of responsibility for their own education." ■

Such problems might include presentation of the bill, follow-up collection letters, and staff performance or attitude, Womack says. In working toward ISO certification, which in part requires surveying customers and then acting on the results, Scripps is conducting patient focus groups.

"We develop questions about things we can fix, and then we ask patients for their input," Womack adds. "We wouldn't want to ask what they think about the UB-92 claim form because we can't change that. However, with our own itemized claim, we have more flexibility."

After one focus review, which involved four patient groups, the results have been interesting, he says. "One thing we heard loud and clear was that people would like to have a financial counselor assigned to them, one person they can go to for the right answer or who will get the answer for them. We were kind of surprised at the overwhelming response."

There likely will be a change in response to this feedback, Womack says, providing it is borne out by quantitative surveys involving larger groups, which will be done next.

In addition to overseeing the ISO 9000 activities **(see related story, p. 65)**, the quality audit specialist will act as a facilitator for the organization's continuous quality improvement (CQI) groups, which have been brought under the ISO umbrella, he explains. "In the business office operation, we currently have eight to 10 CQI groups focused on different parts of the billing process," Womack notes, "each with six to 10 employees from billing and collections."

The new employee also will facilitate ScrippsHealth's QUEST team, a group of 10 directors and managers overseeing most of the ISO documentation effort, which requires a high level of involvement from senior management, he adds.

ISO certification is obtained through an audit, and the quality audit specialist will have the responsibility of organizing that process, as well as overseeing one or more mock audits that will be done before the real thing, Womack says. "Once we obtain certification, the quality audit specialist will be responsible for maintaining that and expanding into other areas of the organization."

Certification for the business office is anticipated by the end of 1999, he notes, at which point the effort will roll out to the entire access department and, eventually, into clinical areas.

A successful candidate for the position must have experience in the ISO certification process and ideally would have, or be willing to obtain, certification as an ISO auditor, Womack says. "The perfect candidate would have done that activity in a health care organization. However, there are not too many hospitals certified at this point, so that may be difficult to find."

Formalizing education

The new compliance educator position comes from ScrippsHealth's intent to formalize the educational process in access management, he says. "There are a lot of professional areas in the hospital that have educational activities built into licensure or certification, but that hasn't been the case for those in [access services]. When we did surveys on how people learned to do their job, we found that we had a lack of formal training and a lot of what we call 'tribal knowledge.' That is knowledge passed from person to person,

Drill to the root of the problem

The cornerstone of the quality initiative at ScrippsHealth in San Diego is its application for ISO 9000 registration, specifically for ISO 9002, the standard that applies to service providers, says **Norma Pearce-O'Toole**, interim quality audit specialist.

The ISO elements, or requirements, having to do with policy and procedure and training are the biggest assets for ScrippsHealth, Pearce-O'Toole points out. "Historically, these areas have not been strengths for many health care organizations. How will you train, and what documentation of these policies and procedures do you have in place?"

The foundation of ISO, she says, is identifying external and internal customers, surveying them on how you're doing, and then acting on those responses. "That is at the core of ISO. It grows into documentation, policy and procedure and ultimately a quality system."

Critical steps in an organization's standard operating procedures (SOPs) must be documented in a standardized format, she explains, along with supporting work instructions — "a detailed how-to." To support these SOP documents, a training standard for all patient financial services' employees will be followed, specific to each job description.

"Structured, ongoing training has been a challenge in patient financial services," Pearce-O'Toole notes. "ISO 9000 has mandated the development of a training plan."

A significant section of the ISO standard relies on the development of an internal audit procedure. "These audits will ensure the continuity of a quality system throughout the year, and not just in preparation for a third-party audit."

[Editor's note: For more on the courseware from M3: The Healthcare Learning Company, write: 1230 Riverbend, Suite 218, Dallas, TX 75247. Phone: (800) 846-4458. Or contact company representative Ernie Burger at (888) 298-0790 or eburger@m3.com.] ■

position to position, but with no documentation on what makes somebody proficient."

Such a system is inherently frustrating for staff seeking to improve their work, he points out. "For those people to be good, they have to be good at something they've only heard about."

The plan, Womack says, is to hire a person for compliance educator with a background in curriculum development, probably with a teaching background, who can develop and conduct educational programs. First of all, these programs would be consistent with the appropriate federal and state regulations, he says. "Next, they would include policies of our various private or other third-party payers and would be specific to the professional needs of the staff."

When applicable, Womack says, the compliance educator will identify existing certification opportunities and will tie the ScrippsHealth program to obtaining that certification. He cites, for example, the Washington, DC-based American Association of Healthcare Administrative Management exam that leads to the certified patient administrative manager credential. "We would see this as a goal for persons interested in obtaining a management position."

The ideal candidate for compliance educator, Womack says, will have strong computer skills because part of the job will include overseeing an on-line educational program the organization recently purchased. **(See related story, p. 64.)**

Much of the educational effort, he notes, has to do with wanting to retain good employees who are frustrated because of the lack of opportunity for advancement. "We will develop tiers within the job structures, and higher tiers will be accessible through completion of these programs. There will be base goals for some, and others for those interested in moving on." ■

ED puts registration to bed with laptops

Support from nurses called critical

As part of its initiative for an electronic medical record and focus on rapid service, Sarasota (FL) Memorial Hospital is registering patients at bedside in the emergency department (ED) using laptop computers.

"It's something new for us," says **Alex Freeman**, director of patient registration. "We got picked as the guinea pig in ED registration." The ED's 16 registration staff, he adds, handle between 64,000 and 66,000 patients a year.

The desks where patients used to sit down and register have been removed, Freeman says. Instead, patients are taken directly to the treatment room, where they are registered by

employees using a laptop mounted on a rolling table, he explains. "It's done in real time, and the information goes directly into our computer system."

The patient's initial encounter is with the triage nurse, either at the ambulance entrance, the ED entrance, or — during its hours of operation — at the adjacent urgent care center, Freeman says. The nurse takes a medical history, assesses the patient's condition, and puts the patient into the care delivery system based on the needs of other patients awaiting treatment, he adds.

"If the patient's first impression is, 'Nobody knows who I am,' what are you doing to instill trust in the patient?"

Until that point, registration personnel haven't seen the patient at all, he says. "Our prompt to be at the bedside is that we're right by the ambulance entrance and can hear the door open, or the rescue crew hands us a copy of the trip sheet, or the nurse may say that a patient arrived. If it's chilly, we feel the draft."

In other words, Freeman stresses, there is no clerical delay to the patient receiving care. "We are tracking flow times and are very focused on rapid service, not having the patient delayed in any way. It's not, 'Register and wait awhile.'"

The laptops use a radio frequency signal from an antenna in the roof, which allows the information to go directly into the hospital's computer database as it is entered, he explains. They are dependent on battery power, which has caused "some bumps in the learning curve," he says. "The issue has been whose responsibility it is to recharge the battery, and when does it get recharged. There are two laptops, and one was [inadvertently] set up without a battery indicator, so it was going dead in the middle of a registration."

Each laptop has two batteries, so there is ample power if someone pays attention to the need for periodic recharging, Freeman says. "We had to make a big point of getting people talking about it. Part of the regular conversation has to be, 'Did you plug it in?'"

Another obstacle came when the laptops began locking up, causing the staff to begin to lose faith in their reliability, he adds. "It wasn't the equipment, but rather that the BIOS [basic input output system] needed to be updated." Information systems personnel found an updated BIOS on the Internet and took care of that problem.

Employees can use two terminals at a central ED station to update a patient's file or register new patients when the laptops are both in use, he says. Plans are to get more laptops as the program is expanded into the urgent care center.

Patient response to the bedside registration has been very positive, Freeman says, and the quality of registrations has improved because the interim step of writing information on a clipboard has been eliminated. **(For tips on how to improve communication with patients, see story, p. 67.)**

The ED nurses deserve much of the credit for the program's success, he points out. "They've been very supportive about inviting the registrar in. If they're busy with treatment and we're an afterthought, it's not going to happen."

Instead, Freeman says, "They have been respectful of the fact that the proper record has to be constructed. Working together this closely has enhanced the relationship between nursing and registration."

Rapid assessment center planned

At present, about 50% of the ED registrations are done on a laptop, but the goal is to expand their use throughout the ED, he says. Future plans also include the establishment of a rapid assessment center (RAC) next to the ED that also would use laptop registration. The idea, Freeman explains, is that Sarasota Memorial's direct admits — who arrive at different hospital entry points since the dissolution of the traditional admitting department — would be directed through a central point, assessed and registered on their way in. The RAC would be for patients who need an immediate admission but are not appropriate for the ED.

One impetus for the RAC, he adds, is that patient satisfaction surveys show the best way to keep patients happy is to be informed about who they are and the reason for their visit. "If the patient's first impression is, 'Nobody knows who I am,' what are you doing to instill trust in the patient?"

Managed care requirements and the move toward outpatient procedures mean that patients arriving from home or from the physician's office to be admitted often are extremely ill, Freeman points out. So, unlike the admitting department, the RAC will be a clinical unit, he says.

Registration staff will be at the bedside in the

RAC, intercepting patients as they arrive and assessing them before they are taken to a nursing unit, Freeman adds. "The largest proportion are elderly, and they're getting older and older. Many of them arrive in wheelchairs."

The anticipated future use of the laptops "is to meet the need of the patient to be interviewed in a more appropriate setting than the traditional admitting department," he says. "It's a quality of care and a customer service issue. It's meeting the needs of the departments we support, like nursing, more efficiently and with more timely information."

[Editor's note: Alex Freeman is interested in talking with other access managers who have implemented laptop registration. Telephone: (941) 917-4297.] ■

Protocols improve patient satisfaction scores

When Louisville, KY-based Hardin Memorial Hospital's emergency department (ED) sought to improve its patient satisfaction scores, staff created a communication protocol.

"Including this in protocols ensures that the patient is getting a higher level of service. Teaching these concepts is one thing, but you also have to formalize it with the protocol," says **Jackie Gerard**, the ED's continuous quality improvement (CQI) coach.

The protocol includes specific instructions for patient communication. "It's a flowchart of what communication needs to happen from the time a patient comes into the ED until he or she is discharged," Gerard explains. "Also, we have a column for family member communication. This explains exactly what the patient and his or her family members need to know at what point. It also addresses which staff member gives information to the family member."

At Emory University in Atlanta, however, some ED staff were uncomfortable making comfort measures part of ED protocols, notes **Doug Lowery**, MD, FACEP, medical director of the ED. "There was an initial resistance to providing nonmedical therapy because it was viewed as something you do at a hotel. So we had to change that part of the culture," he says. "We had to get staff to realize these are basic support functions."

Using protocols to increase comfort is a way to improve satisfaction without additional resources, Lowery says. "It doesn't require an attending physician-level interaction. This can be generated at triage and have a tangible effect on patient satisfaction."

Since the communication protocol has been implemented, patient satisfaction scores have increased significantly, says Gerard. "Our last monthly score for [South Bend, IN-based] Press Ganey was in the 93rd percentile, and when we started out, we were in the lower quarter," she adds.

The following practices are included in the ED patient satisfaction protocols:

1. **Inform patients about the status of their pain management.** When staff at Emory's ED sought to improve pain management, communication issues also were addressed. "We knew our patients weren't happy with the attention given to their pain, says Lowery. "When we were developing the protocol, we realized there were many other ways to impact a patient's perception of pain, other than a pill or shot. So our pain pathway evolved into a comfort pathway."

Just talking about a patient's pain can help relieve it, notes Lowery. "If patients have abdominal pain and we don't give them relief, the patients are afraid they will never get out of discomfort. Now we talk about how much pain they are having, and when they can expect relief," he says. "It just sets patients at ease knowing that they will be treated as soon as it's safe. Instead of magnifying the pain with unnecessary worry, we are taking away that anxiety."

Previously, patients didn't understand why they couldn't receive pain medication instantly, which added to their discomfort. "Now, if we can't immediately give pain medication because we're watching their abdominal pain, we explain when they can get it," says Lowery. "We don't leave them in limbo. The goal is to make sure they realize as soon as it's safe, we will give them something."

Patients are more satisfied with pain management now, he adds. "They feel more strongly now that we're doing everything we can to control their pain. One of the questions on our patient survey cards says, 'Did the staff do everything they could to control pain?' Scores have been gradually rising since we implemented this."

2. **Help patients quantify their pain.** "We quantify the amount of pain patients have at the moment they come in. Some people are very open, and others very stoic, so we've worked with staff to teach patients how to quantify pain," says Lowery.

3. **Provide general comfort measures.** "Patients are offered warm blankets, food, and beverages, and staff make sure they're not too warm or cold. Staff reposition patients who have a hard time moving themselves," he says. "Also, a phone line was put at every bedside." On the nurse's initial assessment form, a checklist includes asking patients about food and drink, making phone calls, and addressing pain medication with physicians.

4. **Escort patients to registration.** Harden Memorial's protocol states that after the triage nurse introduces himself or herself, he or she brings the patient over to registration. "It's very different from just saying, 'Go over there and someone will take care of you.' This is a way of elevating the expectation of the quality of care we deliver," says Gerard.

5. **Use a brochure to explain the stages of an ED visit.** The protocol includes the use of a patient brochure with a detailed map of care to facilitate communication. **(See insert.)** "This helps prepare patients for expectation of delays and ensures they understand the process they're going through," Gerard explains.

The protocol instructs the triage nurses, the ED nurse, physician, patient care assistant, and registration clerk to sign their names on the brochure. "The brochure is taken through the system by the patient, and each caregiver signs his name and explains what the next step is," she adds.

The practice helps patients feel connected with the health care team, says Gerard. "Using our names makes a commitment to the patient in a personal way. We also say, 'If there is anything else I can do, please contact me.' It functions almost like a business card. Also, because we are signing our names, it make the staff members personally accountable."

6. **Use the patient's name at every exchange.** The protocol instructs triage nurses, patient care representatives, nurses, and physicians to introduce themselves, and then use the patient's name in subsequent exchanges.

7. **Explain delays.** The protocol lists the stages of the patient's visit and instructs caregivers to explain delays in each stage. "The registrar gives the patient delay time expectation," Gerard says. If the patient's wait exceeds 10 minutes over the estimated time, the registrar locates the patient in the waiting room and gives updated information.

If there is a wait longer than an hour, caregivers offer specific services instead of general comments. "For example, they may tell the patient, 'I brought you these magazines,'" she says.

8. **Explain procedures.** The protocol stipulates that every stage of the patient's visit must be explained clearly. "For example, the physicians will explain that the patient needs more tests to make a diagnosis and also explain why the test is needed," she notes. "The physicians also communicate with patients about discharge and let them know that the nurse will be in shortly to give them final instructions."

9. **Introduce the patient to other caregivers.** "When the patient is brought to the back, he or she is introduced to other caregivers by name," says Gerard. "It sounds so simple, but it just doesn't happen in most EDs."

Being treated by several people can be confusing to patients, she adds. "We tried to build bridges between caregivers because, from the patient's point of view, people were sort of popping in and out of the room. If the lab test will be going to the lab for analysis, when the doctor orders the test, he or she explains that the nurse will be there in a few minutes. This way, unfamiliar faces aren't just jumping in and out."

That soothes the patient's anxiety, she says. "Although so much teamwork is going on outside, the patient is not aware of that. They just see people are coming in and out who may seem unconnected to their care. Now the patient can understand the coordination of care."

10. **Elect a family communicator.** "We ask the family to elect a communicator, which is part of the protocol," she says. "At times, there may be 12 people waiting for a patient. This way, the family chooses a spokesperson, and it's up to that person to convey information to others." ■

Here's why your Y2K plan probably won't work

Develop 'Plan B' to avoid millennium meltdown

By **Stephen Frew**
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(Editor's note: The following is excerpted from a Y2K contingency manual for emergency department managers written by attorney and risk management consultant Stephen Frew. For more information, see Frew's Web site at www.medlaw.com.)

On Jan. 1, 2000, computers worldwide will transition from the year 1999 to the new millennium represented on many computers and programs as "00" using a two-digit year identifier. This "00" will affect computers in several potential ways.

The first is that the computers will simply and effectively roll over to the new millennial date without incident. Based on testing to date, it appears that fewer than 20% of desktop and laptop PCs will make the transition correctly. Figures for mainframe and mini-computers are estimated to be lower than those for PCs for uneventful transition, but reliable figures are not available.

The second mode is complete failure, where the computer locks up and ceases functioning either temporarily or irretrievably. In "mission-critical" applications, this means the computer will cause a shutdown in the vital functions that it regulates, impair the ability of the institution or business to continue operation, or both.

In recreational or secondary (support) functions, this means that inconveniences will occur that should not seriously impact the ability of a hospital or business to perform its main functions.

The third mode of failure is that the computer will continue to operate but unpredictably provide incorrect data. If the erroneous data are in "mission-critical" positions — such as misstating available inventory so supplies are exhausted unexpectedly or where patient test results are improperly reported and misdiagnosis or mistreatment occur — significant damage can be done to institutional or business functions without warning.

In a sense, the incorrect data may be more damaging than a total cessation of function because the computer users believe that the data are reliable. In a shutdown mode failure, they know there is a problem.

The failure modes that I have just described are certainly bad enough, but many people do not realize that even if we do not use laptops or desktop computers, the year 2000 problem can still have very far-ranging effects, due to what are called "imbedded systems."

These systems are tiny microchips that are imbedded in hardware of all types — applications that you and I are totally unaware of in many cases. We don't think about it, but everything from thermostats, automotive ignition systems, elevator controls, digital watches, and many handheld medical devices — all the way up to navigational satellites, nuclear reactors, cruise missiles, MRIs, and ATMs — is run using computer chips. Heart pacemakers, monitors, dialysis machines, defibrilators, and other medical devices are packed full of the little chips.

No one knows

Not all of these gizmos and gadgets that we have come to base our whole society on are "date sensitive" — not all of them use dates internally. But the problem is that no one — including the manufacturers, sales companies, government, and users — knows which ones are prone to failure and which ones aren't. Even when we do identify ones that might fail, no one can accurately predict exactly how they will fail.

No guarantees on corrections

If year 2000 compliance is not systemwide, you cannot be certain that even corrected elements of the system will function correctly — and even if these systems are fully corrected, there are always the 500 billion or so chips imbedded in hardware that cannot be reprogrammed.

It's too late to fix all of the problems, so we must plan on an unknown level of internal and external failure. And that brings us to why you have to have Plan B developed and implemented prior to Jan. 1, 2000.

We cannot accurately predict the exact level of the failure, the duration of the failure, or the exact impact of the failure on multiple systems in society. For that reason, we have to have a realistic

assessment and plan to meet each of the levels of failure that can be anticipated. Whatever level actually occurs, we will be ready to give it our best effort at delivering emergency services to a confused and potentially disrupted community.

Now, you may be tempted to think that you already have an internal and external disaster plan, and that it has been tested per the Joint Commission on Accreditation of Healthcare Organizations' requirements and has worked OK. Some of you may actually have had to implement your disaster plan in a real emergency.

Those of you who have used a disaster plan probably learned how unrealistic some of them are. Some may have worked well. But none of them — or at least very few of them — are capable of working in anything more than a nominal year 2000 disruption.

Your current disaster plan is not enough. The reason for this is that all of the disaster plans I have reviewed have several fatal flaws:

1. Plans are outdated.

They all are old. They are mostly 1960s-era Cold War nuclear attack plans mixed with snowstorm, tornado, and hurricane elements. They don't address today's technology-related issues, and some presume the use of manual systems that do not even exist anymore. God knows we may well wish they did.

2. Hospitals don't keep inventories anymore.

These plans were written when hospitals kept large inventories of drugs and supplies. Today, drug companies make two deliveries per day in many areas, and daily deliveries in the remainder of instances. "Just-in-time" inventory means that there is never more than three days' supply of drugs, disposables, and food in any hospital on the average Friday. (Jan. 1, 2000, falls on a Saturday.) This means that the ability to provide care begins to deteriorate immediately if there is any interruption in inventory flow. Keep that in mind.

3. They depend on outside assistance.

They all assume that the disaster is local and that they may rely on neighboring communities, state resources, and federal support in a matter of hours, or in a day or two in the worst of circumstances. That may be an unwarranted assumption in the case of the year 2000 crisis. The Y2K crisis could be widespread and could impair all of your neighboring hospitals, immobilize government support, and truly leave you on your own for days, weeks, months, or, in the worst-case scenario, years.

Your Plan B has to be prepared with contingency plans for circumstances from the least to the most disruption and be predicated on the assumption that everyone is having the same problem you are. You have to strive to operate as self-sufficiently as you can for as long as you can. That means a cautious approach to how you expend your available resources.

If you are prepared at this level, and the new millennium comes in with a whimpering hangover and not a major meltdown — great. If, however, it comes in with serious problems, you are prepared to protect the lives and safety of your community in general and your employees in particular. ■

ACCESS FEEDBACK

'What to wear?' debate continues

The proper attire for access employees continues to be a topic of concern to access managers who seek a balance between pleasing the staff and presenting a professional image to customers. In earlier issues, *Hospital Access Management* provided a forum for the debate on whether uniforms should be worn. **(See January and May 1998 issues.)**

Now **Karen Duffy,** MS, manager of patient services for MeritCare Health System, Fargo, ND, raises the question of whether "business casual" attire is a feasible option for access employees.

"Health care organizations have always been pretty conservative about dress codes," she points out. "For some reason, we are held to a higher standard. I'm not sure patients would look at us like they look at a bank when it comes to casual dress."

At her organization, staff who don't interact with patients are allowed more freedom in what they wear, Duffy adds, and she wonders if the same latitude should be given to those who do meet the public. "Has anyone else tried [more casual dress] with patients?" she asks. "Does it work to wear something other than a uniform or business clothes? How about logo items?"

Wearing surgical scrubs is "becoming not an option," Duffy notes, as hospital administration scrutinizes — in a cost-saving effort — who needs to be in scrubs.

"Our staff would like to be more casual, but we fear the public wouldn't be positive about too casual an appearance," she says. "I would like to hear stories of success or failure from those who have tried something like this."

[If you can offer feedback on this issue, please contact editor Lila Moore at (520) 299-8730 or lilamoore @mindspring.com. Karen Duffy can be reached at MeritCare Health System, 737 Broadway #794, Fargo, ND 58123. Telephone: (701) 234-2392.] ■

Happy employees = happy patients, study says

Press, Ganey reports direct correlation

There is a direct correlation between employee satisfaction and patient satisfaction, according to a study by Press, Ganey Associates, a South Bend, IN-based health care satisfaction measurement firm.

Taking a number of hospitals' patient satisfaction and employee satisfaction scores during the same period, the firm plotted the information and calculated the correlation between the two, according to a recent report issued by the company.

Results showed the hospitals with the lowest employee satisfaction had the lowest patient satisfaction, and the hospitals with the highest employee satisfaction had the highest patient satisfaction. The relationship is so consistent, the report explains, that the correlation coefficient, which expresses a perfect relationship as 1.0, was .89, with no outliers.

The report, quoting from studies in *The Manager's Desk Reference* by Cynthia Berryman-Fink and Charles B. Fink of the American Management Association in New York City, says 99% of all employees are motivated by one of the following seven needs: achievement, power, affiliation, autonomy, esteem, safety and security, and equity.

Drawing from the list above, Press, Ganey researchers looked at which issues are most related to employee satisfaction for health care workers. The results show that issues dealing with wages, benefits, and physical environment are not nearly as related to satisfaction as issues of communication, worker attitude, and management practices.

The item most related to overall satisfaction dealt with "the level of pride felt." The item least related to overall satisfaction was "adequacy of medical insurance."

[Editor's note: For additional information on the Press, Ganey report, call the organization at (800) 232-8032.] ▼

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Most hospitals are Y2K compliant, AHA reports

Bulk of costs are in capital

Hospitals will spend up to $8.2 billion to be year 2000 (Y2K) compliant, according to a recent survey by the American Hospital Association (AHA) in Chicago.

On average, the survey found, hospitals with:

- 100 beds or less will spend $436,000 each;
- 100 to 300 beds will spend $1.2 million each;
- 300 to 500 beds will spend $3.4 million each;
- 500 beds or more will spend $8.6 million each.

The survey says most of the hospitals' costs to become Y2K compliant (68%) come from capital expenditures such as modifying or replacing information systems hardware. The other 32% represent operational expenses such as assigning staff to work on Y2K changes and hiring consultants.

The majority of the nation's hospitals expect to be completely Y2K compliant by Jan. 1, the survey results show. Although approximately one-third say they won't be completely compliant, systems directly related to patient care will be. Less than 1% of hospitals currently predict possible "adverse effects" in their critical operations.

More than 60% of respondents cited lack of information from suppliers as the No. 1 barrier to achieving total Y2K compliance.

(For more information, visit AHA's Web site at this address: www.aha.org.) ▼

Profit margins down, hospital analysis shows

Fourth-quarter 1998 hospital operating margins dropped by 45% compared to the same period in 1997, according to an analysis by HBS International (HBSI), a Bellevue, WA-based health care outcomes management company.

Data used for the analysis come from 437 hospitals that have an extended history of reporting quarterly financial and operational data to HBSI.

For full-year 1998, the profit margins of the reporting hospitals, the majority of which are nonprofit, decreased by 24% from the year before, Greg Bennett, president and CEO of HBSI said in a prepared statement. HBSI's analysis also showed that 27% of the hospitals had negative operating margins in the fourth quarter of 1998.

The nation's largest hospitals experienced the most sizable declines. Fourth-quarter operating margins for hospitals with 300 or more beds dropped 51% compared to the same period in 1997, while hospitals with 100 to 299 beds showed a 45% decline, and hospitals with 99 or fewer beds had a decline of 31%.

The area showing the greatest decline was the Southeast Central region (Alabama, Kentucky, Mississippi and Tennessee), with the average margin plummeting 117% — from 3.77% in fourth quarter 1997 to minus 0.66 percent in the fourth quarter of 1998.

The downward trend in margins was consistent across all regions with the exception of the South Atlantic region (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia), which showed a slight increase of 3.4%. ■